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Racial and Ethnic Health Disparities: Is the Gap Decreasing?

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Indiana is rapidly becoming more diverse in its population. This increase is seen in different languages and cultures – in both cities and rural areas. Increasing diversity will create new challenges to the state's ability to care for the health and welfare of its residents. Using the Census 2000 race reporting categories the percentage distributions of racial and ethnic populations in Indiana are:

Percentage	Race/ Ethnicity-
0.30%	American Indian or Alaska Native
1.00%	Asian
0.01%	Native Hawaiian or Pacific Islander
8.40%	African American or Black
3.50%	Hispanic or Latino
87.50%	Caucasian or White

Source: U.S. Census Data, 2000

According to the Indiana Minority Health Plan, the "health care services, treatment outcomes, and health status have improved for the general population, but they have not improved equally or proportionately for all racial and ethnic populations. Inequalities in care, outcomes, and health status contribute to and perpetuate the existence and widening of disparities in morbidity and mortality among Indiana's American Indian or Alaska Native, Asian, Black or African American, and Hispanic or Latino populations. The health of racial and ethnic minority populations living and working in Indiana is reflective of the health of the state, and the state cannot be healthy in the absence of a healthy minority constituency."

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Race and ethnicity not only reflect populations within a geographic region, but influence peoples' experiences and their responses to them. This article will examine race and ethnicity in relation to health disparities. Is the gap between health issues among Whites and other racial ethnic minorities closing or continuing to enlarge?

Challenges

Years of potential life lost (YPLL) are a measurement for premature mortality. YPLL is very helpful in evaluating populations at highest risk for disease and thus help local, state, and federal government in planning for health interventions. According to the United Health Foundation State Health Rankings for 2002, Indiana ranks as the 22nd state in terms of overall healthiness. However, in terms of racial and ethnic disparities, Indiana ranks 40th in YPLL, with Blacks or African Americans suffering 15,120 potential years lost per 100,000 population before age 75 – a potential loss of productive life that is twice as great in the Indiana Black or African American population as it is in the Indiana White population.

In the 2001 mortality report, there are also great differences seen between the White and other racial and ethnic minority populations in relation to certain diseases. For example, the state total age-adjusted death rate for heart disease overall was 261.7 per 100,000 population. Among Whites, the rate was 260.12, whereas for Blacks it was 322.41 per 100,000 population.

There is still a need for accurate data to assess progress in achieving goals that the Indiana State Department of Health (ISDH) has established toward eliminating racial and ethnic disparities. When looking at health statistics for racial and ethnic minorities, there are a few limitations that Indiana faces in relation to data collections. Two of these include:

- **Consistent Reporting**

  Everyone does not report race or ethnicity using data collection tools. This creates inconsistencies, which in turn widen gaps in data reporting.

- **Reporting Primary Language**

  Because the United States and Indiana racial and ethnic populations are growing, English is not the primary language for many people. These individuals depend on family and others in their communities to translate or teach them basic phrases in order to survive daily living. If the primary language is reported, then ISDH and other entities can become more efficient in delivering efficient and better quality of health care by becoming more culturally competent.

Making Strides

The previous limitations are just a few that ISDH faces when eliminating health disparities. However, there are several things that federal, state, and local governments are doing in order to eliminate health disparities:

The Department of Health and Human Services (DHHS) has started an educational campaign designed to make the quality of health an important issue within racial and ethnic minority populations affected by serious diseases and health conditions at higher rates than their White counterparts. The goal of "Take Your Loved One to the Doctor" day encourages individuals to take charge of their health by visiting a health professional, making an appointment for a visit, attending a health event in the community or helping a family member or friend do the same. DHHS and its partners also encourage communities around the country to organize health events on this day. Indiana is participating in this campaign as well. State health officials asked Hoosier residents to "take a loved one to the doctor" on September 16, 2003. The Office of Minority Health also sponsored two events in Indianapolis, a chronic disease presentation, and a "Shower Your Baby with Love, Baby Shower" on September 16, 2003.

In April 2003, the minority health advisory committee, appointed by ISDH, produced a proposal plan called "Healthy Indiana –A Minority Health Plan for the State of Indiana". Four strategic goals capture the primary purpose for proposing, developing, and implementing a minority-specific health plan for the state of Indiana:

- Prepare evidence-based documentation of racial and ethnic health disparities in Indiana;
- Develop a plan of interventional strategies designed to eliminate racial and ethnic health disparities in Indiana;
- Identify and solidify effective public/private, community-based partnerships to help develop, implement, evaluate, and assess outcomes of the proposed interventional strategies; and
- Eliminate disparities in health based on race or ethnicity among Indiana residents such that the "gap effect" for any focus area is less than five percent.

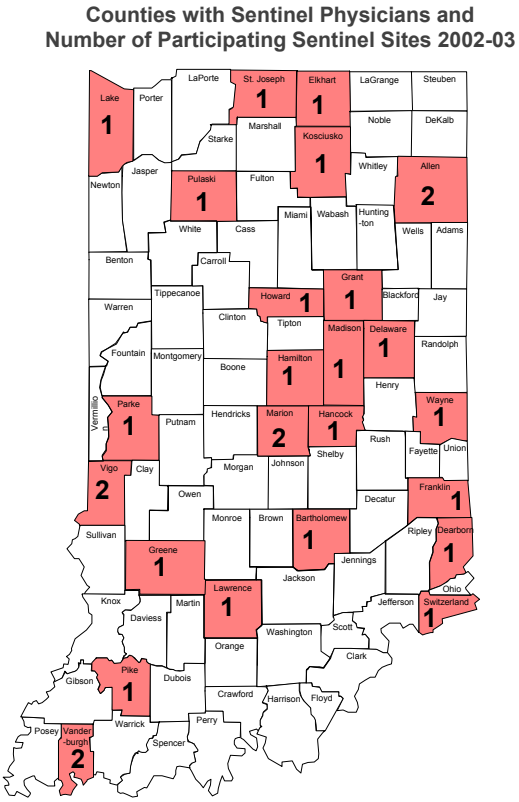
After review of disparities in health and reviewing a few present problems facing data collection efforts, there is a need to change the present health condition of racial and ethnic minorities. Through the continued efforts of ISDH and other entities, we can close the gap of racial and ethnic health disparities and make sure that every resident of Indiana has an equal chance to a healthier and prolonged life.

Indiana Influenza Surveillance 2002-2003

Shawn Richards, BS
ISDH Epidemiology Resource Center

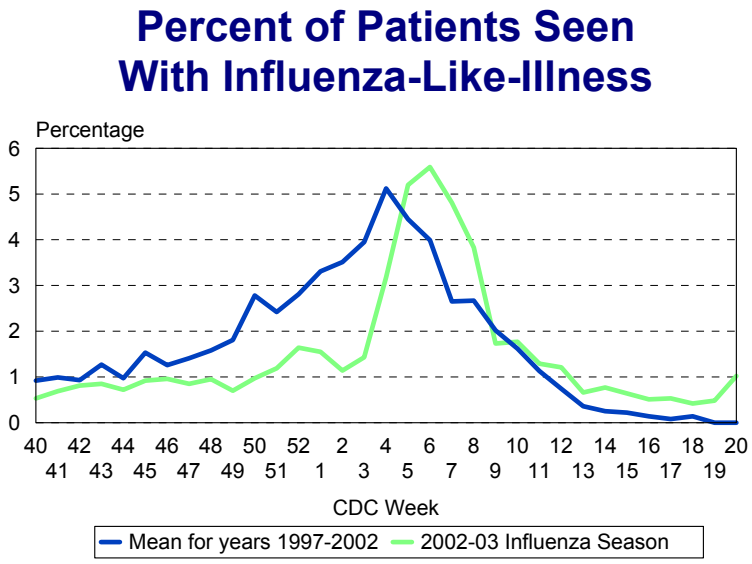
Influenza surveillance during the 2002-03 influenza season was conducted in cooperation with the Centers for Disease Control and Prevention (CDC). Twenty-eight Indiana physicians, nurse-managed clinics, emergency rooms, immediate care facilities, and university student health centers volunteered to be sentinel physicians/sites. Sentinel reporting locations and number of participating sites are provided in Figure 1.

Figure 1.



Surveillance for the 2002-2003 influenza season began the week ending Saturday, October 5, 2002 and continued weekly through May 17, 2002 tracking the numbers of patients presenting for "influenza-like-illness" (ILI). CDC defines ILI for the purpose of surveillance as fever (> 100^0 F [37.8^0 C] oral or equivalent) and cough or sore throat (in absence of a known cause). In addition to tracking how many patients presented with ILI, participants reported the total number of patients, broken down by specified age groups. Sentinel sites compiled weekly reports and submitted them to the CDC repository via Internet, phone, or fax. Additionally, participants collected nasopharyngeal swabs from patients with ILI whose onset of classic clinical signs started within 72 hours of the appointment. The swabs were then sent to the Indiana State Department of Health (ISDH) Laboratories. The ISDH Laboratory conducted viral isolation and identification of influenza viruses by type and subtype. During the surveillance period, 164,880 patients visited sentinel sites of which 2,693 sought care for ILI. A health care facility that wishes to participate as sentinel physician should contact Shawn Richards at srichard@isdh.state.in.us. Figure 2 depicts the findings for the percent of patients seeking care for ILI during the 2002-03 season, as well as a baseline of influenza-like illness for the previous five years.

Figure 2.

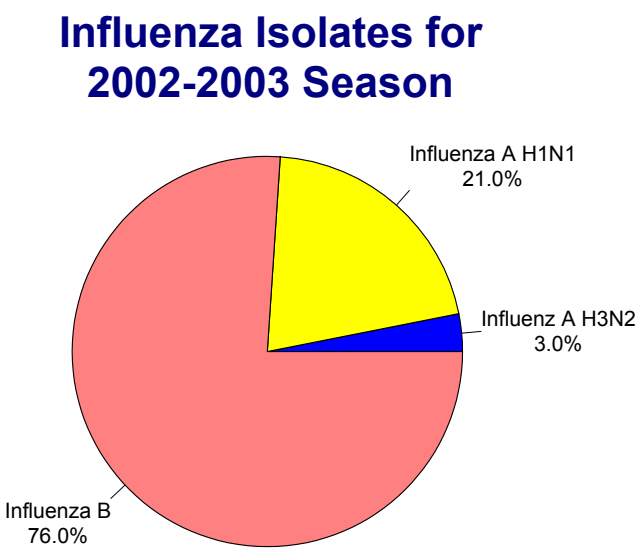


The index case occurred during the week ending 12/13/02. The specimen was typed as Influenza B/Hong Kong by the ISDH laboratories and was obtained from a resident of Clark County. The percentage of patients seen with ILI did not peak until the week ending 03/15/03.

Influenza A and B viruses were widely distributed throughout Indiana. Normally, the dominant virus is influenza A, however that was not the case for the 2002-2003 season. One hundred fifty-one (151) nasopharyngeal swabs from the sentinel physicians were submitted for testing to the ISDH Laboratory. Sixty-six (44%) of the 151 specimens submitted to the ISDH laboratory by the sentinel physicians tested positive for influenza. Fifty (76%) of the positive specimens submitted were sub-typed as Influenza B/Hong Kong. Fourteen (21%) of the positive specimens were sub-typed as Influenza A/H1N1. Two (3%) were sub-typed as Influenza A/H3N2. There was no Influenza C virus identified during the 2001-2002 season.

Figure 3 shows the percentages of sub-typed specimens by the ISDH laboratories.

Figure 3.



Influenza Vaccine for the 2003-04 season

The trivalent influenza vaccine components for the 2003-04 season will include:

- A/New Caledonia/20/99, H1N1
- A/ Panama/2007/99, H3N2 and
- B/ Hong Kong/330/2001

These viruses will be used in this year's vaccine because of their growth properties and their representativeness of the anticipated circulating influenza A and B viruses.

Influenza Vaccine Supply and Production

Vaccine manufacturers are projecting 93 million doses of vaccine for the 2003-2004 season. Although the projected number of doses is 8.5 million doses less than last year's total number of vaccine, 93 million doses far exceeds the number of doses of vaccine available for the 2001-2002 season. There are 3 manufacturers of the influenza vaccine licensed by the United States FDA. Two of the manufactures, Aventis and Powderject Vaccine (Evans) will produce the influenza vaccine in the injectable form. MedImmune will produce it in as an intranasal spray. The nasal spray will be a live vaccine and is not approved for children under five years old or for those individuals for which a live vaccine is contraindicated. The Vaccine Information Statement (VIS) for the new live intranasal vaccine is available on the Internet at www.cdc.gov/nip/publications/VIS/vis-flulive.pdf. The package insert is available at www.fda.gov/cber/label/inflmed061703LB.pdf. The CDC has contacted the influenza vaccine manufacturers and have indicated that 17.5% of the supply will be distributed by the end of August, 52.9% should be distributed by the end of September, 91.8% should be distributed by the end of October, and the remainder distributed by the end of November. Additional information about influenza and the influenza vaccine is available from the CDC at http://www.cdc.gov/nip/flu/default.htm.

Public Law 212-2003 Makes Changes to Indiana Code 16-41-10

Communicable Disease: Exposure Notification for Emergency Medical Services Providers

Communicable Disease: Exposure Notification for Emergency Medical Services Providers (16-41-10) allows for Emergency Medical Services (EMS) providers to request notification of testing following a possible exposure to blood or body fluids. The law stipulates that the exposure must be of a type that has been demonstrated epidemiologically to transmit a dangerous communicable disease. The changes made to this law include, but are not limited to, the following:

- The definition of an EMS provider has been expanded to include a physician licensed under IC 25-22.5, a nurse licensed under IC 25-23, or other person who provides emergency medical services in the course of the person's employment. Firefighters, law enforcement officers, paramedics, and emergency medical technicians are covered by this regulation.
- A patient (including a patient who is unable to consent due to physical or mental incapacity) to whose blood or body fluids an EMS provider is exposed is considered to have consented to:

  (1) testing for the presence of a dangerous communicable disease of a type that has been epidemiologically demonstrated to be transmittable by the exposure; and
  (2) release of the testing results to the EMS medical director or a physician designated by the exposed EMS provider. The EMS medical director or a designated physician will tell the EMS provider the testing results.

The exposed EMS provider who is requesting notification must complete State Form 51467 (9-03), Notification of Blood or Body Fluid Exposure, and submit the form to all of the following:

- EMS medical director;
- If the source patient was admitted to a medical facility either following the exposure or at the time of the exposure, the medical director of the emergency department; and
- The Indiana State Department of Health (ISDH).

State Form 51467 (9-03), Notification of Blood or Body Fluid Exposure, is available at the state forms commission Internet site. The form can be accessed at http://www.state.in.us/icpr/webfile/formsdiv/51467.pdf. Additional information about the law and instructions regarding completion of the form will be available at the ISDH Internet site by the end of September 2003. Public Law 212-2003 (PL 212-2003) can be accessed at http://www.in.gov/legislative/pdf/acts_2003.pdf.

EMS providers and employers should review PL 212-2003. They should also be aware of federal laws specific to exposure to blood or body fluids that occurs while performing job duties. The state and federal laws were developed to ensure that EMS providers receive appropriate medical evaluation after an exposure to blood or body fluids. EMS providers and their employers should become familiar with the following federal laws:

- Ryan White Comprehensive AIDS Resource Emergency (CARE) Act: Emergency Response Employees
- The Occupational Health and Safety Administration's (OSHA) Bloodborne Pathogen Standard

Ryan White (CARE) Act

In 1990, Congress passed the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. Part E of the Act addresses notification of exposure to life-threatening communicable diseases for emergency response employees. It allows for states to follow their own laws regarding emergency response employee notification when the state requirements meet or exceed those set forth by federal law. The requirements of this law include, but are not limited to, the following:

- The development of a list of life-threatening diseases by the U.S. Centers for Disease Control and Prevention (CDC) to which emergency response employees may be exposed and specific guidelines for determining exposure. The list of life-threatening diseases is as follows:
    - Airborne Diseases: Infectious pulmonary tuberculosis
    - Bloodborne Diseases: Human immunodeficiency virus (including acquired immunodeficiency syndrome [AIDS]), hepatitis B
    - Uncommon or Rare Diseases: Diphtheria (*Corynebacterium diphtheriae*), Meningococcal disease (*Neisseria meningitidis*), Plague (*Yersinia pestis*), Hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified)
- The state health commissioner must designate an officer from each employer of emergency response employees to handle follow-up of exposure to certain dangerous communicable diseases.
- Medical facilities must notify the designated officer when an exposure occurs by airborne route or by aerosol. Those diseases include tuberculosis and some of the diseases listed as uncommon and rare life-threatening diseases.

OSHA Bloodborne Pathogen Standard

In addition to the post-exposure medical evaluation, the OSHA Bloodborne Pathogen Standard requirements ensure that employees who handle blood or certain other body fluids are afforded the maximum protection from contracting a bloodborne pathogen. More information about the Standard is available at the following Internet site: http://www.osha.gov/SLTC/bloodbornepathogens/index.html

Employers of EMS providers should be familiar with IC 16-41-10, the Ryan White (CARE) Act, and the OSHA Bloodborne Pathogen Standard when developing policies aimed at protecting EMS providers from contracting life-threatening diseases while performing job duties.

Promed Mail

Promed is an electronic listserve used to communicate real-time disease information worldwide. There is no charge to subscribe. Subscribers can choose to receive all postings, a daily consolidation of postings ("promed-digest"), and postings specific to certain disease topics, such as emerging diseases or zoonotic diseases. Promed postings are also available in Spanish and Portuguese. Subscribers can unsubscribe at any time. There is no "vacation" feature, so for long-term absences, subscribers should unsubscribe and then resubscribe after their return.

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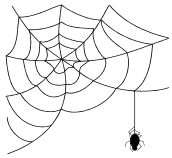

Wonderful Wide Web Sites

ISDH Data Reports Available

The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:

http://www.in.gov/isdh/dataandstats/epidem/epinews_index.htm

Indiana Cancer Incidence Report (1990, 95,96, 97)

Indiana Cancer Mortality Report (1990-94, 1992-96)

Indiana Health Behavior Risk Factors (1995-96, 97, 98, 99, 2000, 2001)

Indiana Hospital Consumer Guide (1996)

Public, Hospital Discharge Data (1999, 2000, 2001)

Indiana Maternal & Child Health Outcomes & Performance Measures (1988-97, 1989-98, 1990-99, 1991-2000)

Indiana Marriage Report (1995, 97, 98, 99, 2000)

Indiana Mortality Report (1999, 2000, 2001)

Indiana Natality Report (1998, 99, 2000, 2001)

Indiana Induced Termination of Pregnancy Report (1998, 99, 2000)

Indiana Infectious Diseases Report (2000)

Former Indiana Report of Diseases of Public Health Interest (1996, 97, 98, 99)

HIV Disease Summary

Information as of August 31, 2003 (based on 2000 population of 6,080,485)

HIV - without AIDS to date:

355	New HIV cases from September 2002 thru August 2003	12-month incidence	5.84 cases/100,000
3,746	Total HIV-positive, alive and without AIDS on August 31, 2003	Point prevalence	61.61 cases/100,000

AIDS cases to date:

438	New AIDS cases from September 2002 thru August 2003	12-month incidence	7.20 cases/100,000
3,468	Total AIDS cases, alive on August 31, 2003	Point prevalence	57.04 cases/100,000
7,251	Total AIDS cases, cumulative (alive and dead)		

REPORTED CASES of selected notifiable diseases

Disease	Cases Reported in August *MMWR* Week 32-35		Cumulative Cases Reported January - August *MMWR* Weeks 1-35	
	2002	2003	2002	2003
Campylobacteriosis	53	96	345	333
Chlamydia	1,400	1,200	11,060	11,223
E. coli O157:H7	8	15	43	58
Hepatitis A	2	8	34	47
Hepatitis B	3	3	32	22
Invasive Drug Resistant *S. pneumoniae* (DRSP)	3	4	125	113
Gonorrhea	546	489	4,748	4,277
Legionellosis	2	4	13	15
Lyme Disease	4	4	14	15
Measles	2	0	2	0
Meningococcal, invasive	2	5	24	36
Pertussis	25	11	61	43
Rocky Mountain Spotted Fever	2	0	3	1
Salmonellosis	80	77	343	393
Shigellosis	10	26	64	107
Syphilis (Primary and Secondary)	2	2	40	35
Tuberculosis	10	6	76	89
Animal Rabies	13 (all bats)	8 (bats)	26 (25 bats, 1 skunk)	15 (14 bats, 1 raccoon)

For information on reporting of communicable diseases in Indiana, call the *ISDH Epidemiology Resource Center* at (317) 233-7665.

Indiana
Epidemiology
Newsletter

The *Indiana Epidemiology Newsletter* is published by the Indiana State Department of Health to provide epidemiologic information to Indiana health professionals and to the public health community.